METHODS AND STANDARDS OF
REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

A. In-State Hospitals

Effective October 1, 1990, reimbursement to hospitals for inpatient hospital services is paid on a prospective per diem level of care payment system with the exception of Indian Health Service Hospitals who are reimbursed at a per diem rate as published by PHS in the Federal Register. There are three distinct payment components under this system. Total per diem reimbursement will equal the sum of:

Level of care per diem

+

Fixed capital per diem

+

Direct medical education per diem (if applicable)

The resulting total per diem will be multiplied by a disproportionate share percentage for qualifying disproportionate share hospitals.

Level of Care Per Diem Rates - The level of care per diem rates are payments for allowable operating costs and movable capital costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. No return on equity is included in the per diem rate. There are eight levels of care. For each level of care category, the payment rate was established at the median cost per day for providing services within that level of care. Cost per day within each level of care was calculated using the following steps:

a. Claims were categorized into levels of care.
b. Using uniform cost report information for the corresponding time period, charges submitted on the claims were converted to costs using facility-specific cost-to-charge ratios (fixed capital and direct medical education costs were removed at this time).
c. All costs were inflated to a uniform point in time (the midpoint of the state's payment year).
d. Peer grouping analyses were performed to evaluate statistically significant differences in costs across categories of hospitals (e.g., teaching versus nonteaching).
e. The median cost per day was calculated for each level of care category.

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When submitted for payments, claims are classified into these levels of care based on revenue codes, diagnosis codes and/or procedure codes. Each of these levels of care, and the basis used to assign claims into a particular level of care are listed below:

Level of Care		Basis of Assignment
1.	Burn Care	Presence of burn unit revenue code charges
2.	Neonatal Intensive Care Unit (NICU) Unit	Presence of neonatal intensive care revenue code changes on NICU claims from Level III NICU providers
3.	Maternity Care	Diagnosis codes
4.	Surgical Care	Presence of surgical revenue code charges including C-sections. Specified routine inpatient surgical procedures are excluded.
5.	Rehabilitation Care	Range of primary and secondary diagnosis codes
6.	Psychiatric Care	Range of primary diagnosis codes
7.	Intensive Care Unit/ Coronary Care Unit	Presence of Intensive Care Unit/ Coronary Care Unit revenue code charges
8.	Routine Care	All remaining days and specified routine inpatient surgical procedures.

Claims are classified into each of these levels of care based on the hierarchy shown above, with claims potentially classifying into Level 1 first, then Level 2, and so forth. Payment for claims classified into Levels 1-6 and Level 8 is made at a single level of care rate. Reclassifications of surgical procedures between levels 4 and 8 would be considered a change in the payment methods and standards requiring a state plan amendment.

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The only two exceptions to this logic are for payment for claims in Level 7 and for payment for routine inpatient surgical procedures. Payment for claims classified into Level 7 will be made at two level of care rates when a claim has both ICU/CCU revenue code charges and routine revenue code charges. When this occurs, payment is split between Levels 7 and 8. Claims for a single stay shall not be split and submitted as two claims solely for the purpose of obtaining two different level of care payment rates (except when patients receiving psychiatric care in acute care hospitals are transferred to medical units because their non-psychiatric medical needs become the primary cause of hospitalization). There are two restrictions on these levels of care:

1. Only Level III neonatal units will be paid the NICU level of care per diem rate. For rate setting purposes a hospital is considered eligible to receive the Level III NICU rate if it meets the criteria used by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey.

2. All claims from free-standing inpatient psychiatric hospitals will be paid at the Level 6, Psychiatric, level of care rate. (Psychiatric claims from acute care hospitals will also be paid at the Level 6 rate).

Payment rates for Level 7 (ICU/CCU) and Level 8 (Routine) are peer grouped based on hospital teaching and nonteaching status. For payment purposes, hospitals that either (1) belong to the Council on Teaching Hospitals, or (2) have a medical school affiliation qualify for the teaching peer grouped rate for Levels 7 and 8. All other hospitals receive the nonteaching rate for Levels 7 and 8.

The second exception provides for payment of specified routine inpatient surgical procedures at the routine care per diem rate instead of the surgical care per diem rate. This exception is effective for services provided on or after May 1, 1994.

These level of care rates are calculated from 1988 claims and uniform cost report data from each provider's fiscal year ending in calendar 1988. Costs were inflated to a common point of time prior to calculation of the median cost per day.

Level of care per diem rates are inflated annually effective July 1 of each year using the lesser of the available Data Resources, Inc. (DRI) PPS-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year or the latest Health Care Financing Administration (HCFA) proposed update factor for non-PPS (exempt) hospitals published in the Federal Register or in federal legislation, whichever is later, prior to the start of the state fiscal year. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year solely as a result of later available forecasts or actual inflationary changes.

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For services on or after February 1, 1993 through June 30, 1993, hospitals with allowable costs above the statewide median level of care will be limited to reimbursement of the statewide median level of care rate, except for levels 7 and 8, which will not exceed the peer group median. When a hospital's allowable costs are less than the statewide median level of care, 62.5 percent of the difference will be added to the hospital's specific facility level of care rate. Beginning July 1, 1993, the add-on to the facility specific level of care rate will be 25 percent of the difference between the statewide median level of care rate (except levels 7 and 8) and the hospital's specific level of care rate.

Hospital-specific costs per day within each level of care were calculated using the following steps:

a. Claims were categorized into levels of care.
b. Using uniform cost report information for the corresponding time period, charges submitted on the claims were converted to costs using facility-specific cost-to-charge ratios (fixed capital and direct medical education costs were removed at this time.)
c. All costs were inflated to a uniform point in time (the midpoint of the state's payment year.)
d. Peer grouping analyses were performed to evaluate statistically significant differences in costs across categories of hospitals (e.g., teaching versus nonteaching).
e. Facility-specific costs per day were calculated for each level of care category.

These hospital-specific rates are calculated from 1988 claims and uniform cost report data from each provider's fiscal year ending in calendar 1988. Costs were inflated to a common point of time prior to calculation of the facility specific costs per day.

Facility-specific per diem rates are inflated annually effective July 1 of each year using the first quarter publication of the Data Resources, Inc. (DRI) PPS-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year, prior to the start of the state fiscal year.

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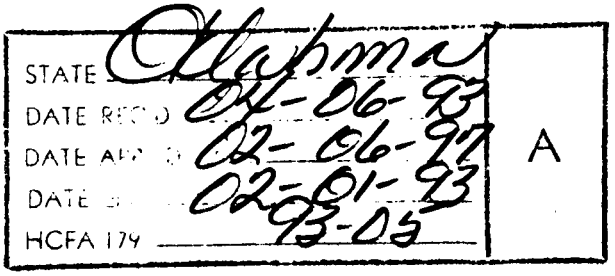
Cost Variance Adjustment

The distribution of cost coverage for in-state facilities will be the basis for the cost variance adjustment. Cost coverage is the percentage determined by dividing actual payments by actual costs (actual cost coverage) or actual payments by reimbursement plan costs (allowed cost coverage). The cost variance adjustment factor (CVAF) will be determined, based on findings analysis, from the difference in actual cost coverage and allowed cost coverage at the 50th percentile of the distribution. The actual amount of the adjustment factor applied to the inflated rates will be based on the availability of funds, but will not exceed the variance.

For purposes of this amendment effective February 1, 1993, the finding analysis was for State Fiscal Year 1991, and the CVAF was 2.3%. Effective February 1, 1993 to June 30, 1993, 37.7% of the CVAF will be applied to the statewide and peer group medians, and 45.5% of the CVAF will be applied to the facility-specific per diems. Effective July 1, 1993, 63.1% of the CVAF will be applied to the statewide and peer group medians, and 78.2% to the facility-specific per diems. These adjustments will not be applied cumulatively; the July 1, 1993 adjustments will be built permanently into the rates.

Fixed Capital Per Diem Rate - The fixed capital per diem rate is payment for allowable fixed capital costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. No return on equity is included in the per diem rate. The rate is calculated separately for acute care hospitals and free-standing psychiatric hospitals using different methodologies.



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1. Fixed capital per diem methodology for free-standing psychiatric hospitals. Inpatient psychiatric hospitals fixed rate capital cost will be reimbursed using the average fixed rate capital cost of all Medicaid enrolled free-standing psychiatric inpatient hospitals from calendar year 1991 cost reports.

2. Fixed capital per diem methodology for acute care inpatient hospitals. Inpatient hospital fixed capital per diem cost will be reimbursed using a peer group fixed capital weighted payment method. There are five peer groups based on level of care of the services offered:

   The weighted fixed capital component will be calculated as follows:

   Step 1. Hospitals will be divided into categories based on level of care of the services offered using the statewide or peer group medians. As of February 1, 1993, there are five categories:

   1. Teaching hospitals with burn and NICU units.
   2. Teaching hospitals with NICU units, but no burn unit.
   3. Teaching hospitals without NICU or burn unit.
   4. Non-teaching hospitals with NICU units, but no burn unit.
   5. Non-teaching hospitals with no burn or NICU unit.

   Additional categories will be determined for hospitals that do not fall within the categories listed in Step 1 above. A new plan page will be submitted if it is determined that additional categories are needed.

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Step 2. The sum of all levels of care offered within a category will be divided by the number of patient levels of care offered within a category to arrive at an average per diem for each category.

Step 3. A value factor for each patient level of care within a category will be determined by dividing the operating (level of care) prospective rate for each level of care by the average operating (level of care) prospective rate for each category.

Step 4. The value factor (from Step 3) will be multiplied by the statewide median per capital per diem to arrive at the weighted fixed capital per diem reimbursement rate.

3. Adjustments. The statewide median per diem capital amount is calculated from 1989 uniform cost report data from each fiscal year ending in calendar 1989. Costs were inflated to a common point in time prior to calculation of the median capital cost per day. The statewide fixed capital per diem average of all free-standing psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals are annually inflated effective July 1 of each year by the latest one year District Comparative Cost Multiplier for the Central Region, Class A Construction, in the January edition of the Marshall Valuation Services, published by Marshall & Swift. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year using later available forecasts or actual inflationary changes.

New in-state hospital providers (this does not include hospitals having a change of ownership) lacking 12 months of cost report information shall receive the statewide capital per diem amount. After submittal of the first full year's cost report, capital payments will be in accordance with the methodology described above.

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Direct Medical Education Per Diem - The third rate component, a hospital-specific direct medical education per diem, is paid to those hospitals with allowable direct medical education costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. New hospitals must have 12 full months of cost report data in order to receive a hospital-specific direct medical education per diem. The medical education per diem will be inflated effective July 1 of each year using the lesser of the available DRI PPS-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year or the latest HCFA proposed update factor for non-PPS (exempt) hospitals published in the Federal Register or in federal legislation whichever is later, prior to the start of the state fiscal year. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year solely as a result of later available forecasts or actual inflationary changes.

A cost variance adjustment factor (CVAF), or a percentage of the factor, will be applied prospectively to the inflated direct medical education per diems prior to the start of the State fiscal year under the conditions described on Attachment 4.19-A, Page 4.

B. **Out-of-State Hospitals**

Hospitals, for which the department has on file a fiscal year 1989 or more recent full year cost report, are reimbursed the same as in-state Oklahoma hospitals.

Hospitals, for which the Department does not have a fiscal year 1989 or more recent cost report on file, will also receive the level of care per diem rates. However, capital and direct medical education rate components will not be reimbursed on a hospital-specific basis. Instead, these hospitals shall receive the statewide median capital per diem amount. The statewide median direct medical education per diem rate will be paid to qualifying hospitals.

In the absence of substantiating information verifying eligibility for the teaching hospital peer group, an out-of-state hospital will be presumed to be a non-teaching hospital and will be paid at the non-teaching rate for levels 7 and 8. A retroactive adjustment will be made for the difference in the teaching/non-teaching rates if eligibility is subsequently determined for services ~~provided on or after the effective~~ date of eligibility.

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In the absence of substantiating information verifying the presence of a burn unit or a Level III NICU, an out-of-state hospital will be presumed to be ineligible for burn and NICU level of care payments.

Out-of-state hospitals shall submit to the Department substantiating information (as appropriate) to verify qualification as a teaching hospital, to verify presence of a burn unit and to verify presence of a NICU which meets Level III criteria established by the Health Planning Commission.

C. **Provider Rate Appeal**

1. Appeals Procedure

a. Any hospital (excludes residential psychiatric treatment facilities) seeking an exception from the statewide or its peer group rate for any level of care, or an adjustment to the hospital-specific fixed capital or medical education component of its rate, shall submit a written request to the Director of the Department of Human Services ("Department"), with a copy to the Medical Services Division, within 30 days after receipt of the letter notifying the hospital of its rate, unless permitted to do otherwise under paragraph 3 below. This time period may be extended (i) upon agreement between the Department and the hospital or (ii) by the Department upon the hospital's submission of a request for an extension of time, within the thirty-day period, showing good cause for the extension.

b. The written request for an exception or other rate adjustment must contain the information specified in paragraph 1(c). The Department will acknowledge receipt of the written request within 30 days after actual receipt. The Department may request additional documentation or information from the hospital as may be necessary for the Director to render a decision. The Director shall make a decision upon the hospital's request for an exception or adjustment within 90 days after receipt of all additional documentation or information requested. The decision of the Director shall be the final decision of the Department.

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c. Any request for an exception to the statewide or peer group rate or other rate adjustment must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) the reasons or factors that the hospital believes justify an adjustment. In addition, the request must include an analysis demonstrating the extent to which the hospital is incurring or expects to incur a marginal loss (as defined in paragraph 1(d) in providing covered services to Title XIX Medicaid clients. The hospital will not be required to present an analysis of marginal loss where the basis for its appeal is limited to a claim that the rate-setting methodology or criteria for classifying hospitals or hospital claims under the State Plan were incorrectly applied, that incorrect or incomplete data or erroneous calculations were used in establishment of the hospital-specific rate, or that the hospital has incurred additional costs because of a catastrophe that meets the conditions specified in paragraph 3 of these rules.

d. For purposes of these rules, "marginal cost" means a hospital's total variable costs incurred in providing covered inpatient services to Title XIX Medicaid clients. In calculating marginal cost, a hospital shall assume that the ratio of variable costs to total allowable costs is 60% (which is the inpatient hospital marginal cost ratio established in regulations of the Health Care Financing Administration (HCFA)); however, the hospital may present an analysis employing a different ratio of variable costs to total costs if the hospital is able to demonstrate that a different ratio is appropriate for its particular institution. "Marginal loss" as used in these rules means the amount by which the hospital's marginal cost exceeds the total Title XIX Medicaid reimbursement (excluding any disproportionate share payment adjustments) paid to the hospital for inpatient services.

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